STATE OF SOUTH CAROLINA

JOINT CITIZENS AND LEGISLATIVE COMMITTEE ON CHILDREN

2011 ANNUAL REPORT

FEBRUARY 1, 2011

JOINT CITIZENS AND LEGISLATIVE COMMITTEE ON CHILDREN
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STATE OF SOUTH CAROLINA

JOINT CITIZENS AND LEGISLATIVE COMMITTEE ON CHILDREN

February 1, 2011

Governor Nikki R. Haley, President *Pro Tempore* Glenn F. McConnell, Speaker Robert W. Harrell, Jr., and Members of the General Assembly:

As Chair and Vice-Chair of the Joint Citizens and Legislative Committee on Children, we are pleased to present the Committee's 2011 Annual Report regarding the status of children in South Carolina. Our State faces critical issues in its efforts to promote the safety and well-being of our children. The Committee offers a forum of citizens, legislators, and agency directors to study the needs of children and to promote effective, efficient strategies to address children's problems.

In this first Annual Report, the Joint Citizens and Legislative Committee on Children presents a comprehensive overview of the myriad of issues facing the children of our state. The Annual Report contains selected data which present a compelling overview of those children in need and more specifically focuses on the children who have been placed in the custody of the State. Central to this theme are services for child protection and welfare, juvenile justice, and mental health.

The 2011 legislative session offers new leadership and ideas as we attempt to balance the needs of children with the realities of declining resources. The main impact on children's services this year will likely result from budgetary decisions. Informed consideration will allow our best efforts to provide cost-effective, coordinated services that mitigate the impact of the more serious problems on South Carolina's children and promote the well-being of children. Please call upon the Committee to assist with research and study of children's issues when we may be of service to you.

On behalf of the Joint Citizens and Legislative Committee on Children, thank you for your consideration of this important report.

Michael L. Fair
Chair

Joan B. Brady
Vice-Chair

2011 Annual Report
Joint Citizens and Legislative Committee on Children
Table of Contents

2011 Annual Report
Joint Citizens and Legislative Committee on Children
Preface

There are 1,089,000 children living in South Carolina. Consistent with its history, last year South Carolina was ranked 45th in the nation by the Annie E. Casey's annual *Kids Count Data Book* in its comparative ranking of the well-being of its children.[1]

State data reflect that in the last year, approximately:

- 462,000 of children lived in some officially measured degree of poverty[2]
- 485,000 of children qualified for Medicaid benefits in any given month[3]
- 370,000 received subsidized school meals[4]
- 100,000 received special education services[5]
- 25,000 children with mental health disorders went untreated[6]
- 37,000 children were the subject of child abuse investigations[7]
- 8,300 children lived in foster care [8]
- 20,000 cases of delinquency were referred to the family courts[9]
- 27% of children who start school will not graduate[10]

There are many important issues regarding children that have not received sufficient study and policy attention since the elimination of the Joint Legislative Committee on Children in the early 1990's. However, out of the necessity created by our collapsing financial circumstances, this Annual Report gives its initial attention to those children who live in the custody of the State. Accordingly, the primary focus is on children receiving child protection, juvenile justice, and mental health services.

During the 2011 legislative session, the main impacts on children will likely come from budget decisions. It is imperative that we anticipate the consequences of these decisions, and that we maximize and coordinate services for children.

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[1] The Annie E. Casey Foundation, Kids Count, http://datacenter.kidscount.org/data/acrossstates/Rankings.aspx?ind=137 (last visited January 18, 2011).

[2] National Center for Children in Poverty, Demographics of Low-Income Children, http://www.nccp.org/profiles/state_profile.php?state=SC&id=6 (last visited November 9, 2010).

[3] S.C. Department of Health and Human Services, Medicaid Management Information System, Medicaid Eligibles, Final Report, Statewide Summary, June 2010

[4] S.C. State Department of Education, Quick Facts: Education in South Carolina, https://apps.ed.sc.gov/agency/Accountability/Data-Management-and-Analysis/old/research/documents/QuickFacts-100801-1.pdf (last visited January 18, 2011).

[5] S.C. State Department of Education, South Carolina's Exceptional Children's Statewide Data Collection History, Child Count, 2008 South Carolina Summary 3-21. http://ed.sc.gov/agency/Standards-and-Learning/Exceptional-Children/OECData/DataCollectionHistory.html (last visited January 18, 2011)

[6] National Survey of Children's Health, Search Data Sets, 2007 NSCH, Child Health Measures, South Carolina, Healthcare Access and Quality, Received Needed Mental Healthcare, http://nschdata.org/Content/Default.aspx (last visited January 18, 2011).

[7] S.C. Department of Social Services, unpublished report , Gender Breakout of All Children Involved in a CPS Investigation with Decision Date SFY 06-10.

[8] S.C. Department of Social Services, unpublished report, Key Stats from Child Welfare Services, December 2010. This number represents the total number of children for the fiscal year. At any point in time, there may be 5,000 children in Foster Care.

[9] S.C. Department of Juvenile Justice, Annual Report Card 2008-2009, http://www.state.sc.us/djj/pdfs/2008-Report-Card.pdf (last visited January 18, 2011).

[10] South Carolina State Board of Education, What is a Penny Buying for South Carolina: Twenty-Fourth Annual Reporting on the South Carolina Education Improvement Act of 1984, South Carolina Graduation Rates and Dropout Rates: A Primer. December 2008.

This 2011 Annual Report of the Joint Citizens and Legislative Committee on Children provides information regarding the children of South Carolina to inform the Governor and the General Assembly in the consideration of policy, funding, and legislation which affects children. The Committee looks forward to working with legislators and other elected officials, citizens, and all who serve or who are interested in promoting the well-being of children.

2011 Annual Report of the Joint Citizens and Legislative Committee on Children

Executive Summary

It is well documented and universally understood that the well-being of children in South Carolina is unacceptably low regarding their education, socio-economic status, child protection, health, and various other risk factors. The Children's Policy of South Carolina affirms that children's services shall strengthen and encourage family life and serve and protect all children. The Joint Citizens and Legislative Committee on Children was created to identify and research children's problems and to inform the Governor and General Assembly regarding efforts to thoughtfully consider and oversee efforts to enhance families and to protect and promote the healthy development of children. This 2011 Annual Report confirms:

- One-half of the children in our State live with some problem or unacceptable situation;
- For most of these children, their problems can be successfully resolved or mitigated;
- The State has a special duty to serve and support those children who have been removed from their homes and placed in State custody;
- The cost of prevention or intervention to resolve children's problems is almost always less expensive than the cost of failing to serve them;
- Children whose problems go undetected or unresolved often grow up to become dependent on the State for a lifetime of programs and support;
- The children in need (and their families) and the agencies that assist and serve them are being profoundly, negatively impacted by the current economic crisis;
- Budgetary decisions will render the biggest impact on children during this year; and,
- All legislative and policy decisions must consider both the intended and the unintended consequences to children that will follow.

More detailed findings and recommendations are presented in the attached 2011 Annual Report which can also be found by visiting http://childlaw.sc.edu/JointCommittee.asp.

Children in State Custody:

Child Protection: Annually, over 12,000 children are abused or neglected; over 8,000 of these children will be placed in foster care.[11] Methods to enhance "family preservation" should include evidenced-based programs designed to quickly focus on and resolve specific family problems, emphasis on faith-based initiatives, and greater consideration given the prevalence of alcohol and drug abuse issues within families in child protection cases. Abuse and removal from home are traumatic for children. Reunification with a competent family or permanency and stability through adoption is critical to each child.

[11] S.C. Department of Social Services, unpublished report generated December 2010. Ages of Children Served in Foster Care by Office During FY 09-10.

Juvenile Justice: Annually, over 15,000 children are referred to the family court system for some type of delinquent behavior.[12] Most of these juveniles are referred for relatively minor and non-violent offenses. Approximately 5000 juveniles are supervised under community supervision, and some 200 are incarcerated in long-term commitment. [13] [14] More serious, but non-violent child offenders are successfully served in alternative community wilderness programs. Generally, these youth come from backgrounds of low income and often experience learning disabilities, poor school performance, emotional and mental disorders, and family dysfunctions which may include abuse or neglect. The State must sustain its efforts to direct children with problems who are not a danger to the community away from incarceration.

Children's Mental Health: A child with an untreated mental disorder will carry that problem into each stage of adolescence -- and ultimately into adulthood. As children age into school, the learning process and expanded social interactions will place increasing demands on them. While over 30,000 children did receive mental health services, another 25,000 are estimated to go without any needed mental health services.[15] [16] Whether a child's mental health issue is temporary, or will be a life-long condition, these are children whose lives can be improved by greater access to mental health diagnosis and treatment. Regular, sustained community and school-based mental health services may reveal circumstances of child abuse or neglect, treatable depression, or other problems that can be successfully resolved at the onset. Missed opportunities to address children's mental health issues have serious financial and social consequences.

The Joint Citizens and Legislative Committee on Children is committed to its responsibility to identify, study, and address children's issues. Through an effective process of data collection, research, and study, the Committee shall strive to inform the consideration of children's issues.

[12] S.C. Department of Juvenile Justice, Annual Report Card 2008-2009, http://www.state.sc.us/djj/pdfs/2008-Report-Card.pdf (last visited January 18, 2011).
[13] S.C. Department of Juvenile Justice, Plan for Continuing Juvenile Justice Reform in South Carolina: 2011-2015, Draft generated October 4, 2010
[14] S.C. Department of Juvenile Justice, 2009-2010 Annual Statistical Report, http://www.state.sc.us/djj/pdfs/2010%20Annual%20Statistical%20Report.pdf (last visited January 18, 2011)
[15] National Survey of Children's Health, Search Data Sets, 2007 NSCH, Child Health Measures, South Carolina, Healthcare Access and Quality, Received Needed Mental Healthcare, http://nschdata.org/Content/Default.aspx (last visited January 18, 2011).
[16] S.C. Department of Mental Health, Annual Statistical Report, Fiscal Year 2009-2010, http://www.state.sc.us/dmh/09_accountability_report.pdf (last visited January 18, 2011). Compilation provided by SCDMH.

I. Introduction:

A. The Children's Policy of South Carolina:

The General Assembly enacted the Children's Policy for South Carolina to affirm that all laws and regulations to provide for children's services should strengthen and encourage family life, serve and protect all children. This Policy applies to all children including those who are mentally, socially, economically, physically, developmentally, culturally, educationally, or economically disadvantaged or disabled; those who are neglected or abused; and those who violate the laws of South Carolina and are in need of rehabilitation. [17]

The Children's Policy of South Carolina includes the following as guiding principles for children's services:

- Prevent children's problems
- Encourage community involvement in the provision of services
- Maximize resources and coordinate children's services
- Strengthen and encourage family life
- Serve of children in the least restrictive environment
- Protect children from harm
- Unify children with their families
- Place permanently and facilitate adoption for children who cannot return home
- Provide child services based on the greatest need

These guiding principles direct state leaders to concentrate efforts and resources on preventing children's problems as the most important strategy for children and their families.[18]

The Children's Policy of South Carolina Provides:

> The State shall encourage community involvement in the provision of children's services including, as an integral part, local government, public and private voluntary groups, public and private nonprofit groups and private-for-profit groups in order to encourage and provide innovative strategies for children's services. To maximize resources in providing services to children in need, all agencies providing services to children shall develop methods to coordinate their services and resources. For children with multiple needs, the furtherance of this policy requires all children's services agencies to recognize that their jurisdiction in meeting these children's needs is not mutually exclusive.[19]
>
> When children or their families request help, state and local government resources shall be utilized to compliment community efforts to help meet the needs of children by aiding in the prevention and resolution of their problems. The State shall direct its efforts first to strengthen and encourage family life as the most

[17] S.C. Code Ann. §63-1-20(B) (2010).
[18] S.C. Code Ann. §63-1-20(D) (2010).
[19] S.C. Code Ann. §63-1-20(C) (2010).

> appropriate environment for the care and nurturing of children. To this end, the State shall assist and encourage families to utilize all available resources. For children in need of services, care and guidance the State shall secure those services as are needed to serve the emotional, mental and physical welfare of children and the best interests of the community, preferably in their homes or the least restrictive environment possible.[20]
>
> When children must be placed in care away from their homes, the State shall insure that they are protected against any harmful effects resulting from the temporary or permanent inability of parents to provide care and protection for their children. It is the policy of this State to reunite the child with his family in a timely manner, whether or not the child has been placed in the care of the State voluntarily. When children must be permanently removed from their homes, they shall be placed in adoptive homes so that they may become members of a family by legal adoption or, absent that possibility, other permanent settings.[21]
>
> The children's policy provided for in this chapter shall be implemented through the cooperative efforts of state, county and municipal legislative, judicial and executive branches, as well as other public and private resources. Where resources are limited, services shall be targeted to those children in greatest need.[22]

A balanced policy for the protection and development of children should emphasize a strategy of both the prevention of children's problems and the provision of children's services. The pursuit of prevention should promote positive child development for all children, especially by fostering child-supporting assets through nurturing family life and community involvement. Many children with special needs are dependent on State and community support, especially through public schools, service agencies, and faith-based organizations. These entities should provide assistance that is responsive to the children's needs and problems and promotes positive family values, a meaningful education, and the development of life skills to enable successful employment and citizenship. Those children without nurturing or capable families also require protective intervention by the State and greater assistance to overcome their critical personal challenges.

[20] S.C. Code Ann. §63-1-20(D) (2010).
[21] S.C. Code Ann. §63-1-20(D) (2010).
[22] S.C. Code Ann. §63-1-20(E) (2010).

B. The Joint Citizens and Legislative Committee on Children:

The Joint Citizens and Legislative Committee on Children (the Committee) was enacted to research and report on children's issues, findings, and recommendations to the Governor and the General Assembly. The Committee identifies problems, collects information, studies issues, and recommends efforts to best address children's problems.[23] The Committee takes guidance from the Children's Policy of South Carolina and the General Assembly. The Committee serves as a clearinghouse for children's issues and will publish an annual report regarding the children of South Carolina.

The Committee's membership includes three Senators appointed by the President *Pro Tempore* of the Senate, three Representatives appointed by the Speaker of the House, three citizens appointed by the Governor, and the following ex-officio members: the State Superintendent of Education, and the Directors of the Departments of Disabilities and Special Needs, Health and Environmental Control, Juvenile Justice, Mental Health, and Social Services. This diversity of roles and perspectives of legislators, agency directors, and citizens facilitates discussion of issues related to children's well-being and the systems that impact child development.

[23] S.C. Code Ann. §63-1-50 (2010).

II. Services for Those Children Who Live in State Custody:

While the general profile of children in South Carolina includes hundreds of thousands of children with problems, the most vulnerable of these children are those whom the State has removed from their homes and placed in the custody of the State. These children have been abused or neglected, suffer mental disorders, or are delinquent -- or some combination thereof. The State accepts an elevated duty to assure needed care for the children removed involuntarily from their homes and placed in unfamiliar foster homes or institutional facilities. In essence, the State has assumed the role of parent, and the State must now provide the child with the protection and nurturance that was not being provided by his parents. The State must not fail to be a good and supportive parent to these children living in state custody. There are additional children in need of support, protection, or supervision who have left their homes to reside with extended family members or friends. These children live only one step away from being in state custody, and the failure to fully assist them could result in more children moving into costly state care.

The following three sections address the critical needs of children who have been taken from their homes and placed in the custody of the State. These children are being served in the agency program areas of child welfare and protection, mental health, or juvenile justice (sometimes by multiple agencies). Their needs are highlighted by the Committee for special attention during this time of fiscal crisis. The State has removed these children from their homes, assumed responsibility for their welfare, and must provide them with necessary care.

A. Child Welfare and Protection:

The State has a legal responsibility to intervene when parents abuse or neglect their children. Ideally, child protection responses would include: (1) primary prevention activities to keep abuse and neglect from occurring in the first instance; (2) early intervention to keep children safe in their families, or to achieve successful reunification when removal has been necessary; and (3) timely permanency for the child through adoption or kinship placement if reunification is not possible. Approximately 19,000 cases of possible child abuse or neglect were referred to DSS in 2010 for investigation.[24] DSS is responsible to intervene on behalf of South Carolina and to investigate these cases, determine whether abuse or neglect occurred, and, when needed, develop treatment plans which may include protective removal of children from their homes.

Child maltreatment encompasses a wide range of situations from the failure to provide necessary care to severe physical or sexual assault, including homicide. Most cases reported to the child protection system (CPS) involve neglect rather than overt acts of abuse. Of the approximately 19,000[25] cases referred for investigation, DSS investigations resulted in finding that 6,705[26] cases were indicated for maltreatment. Because many cases involved families with more than

[24]S.C. Department of Social Services, Unpublished report generated December 2010, CPS Investigations during SFY2010, (Data from DAPSS on August 31 - Planning and Quality Assurance).

[25] S.C. Department of Social Services, Unpublished report generated December 2010, CPS Investigations during SFY2010, (Data from DAPSS on August 31 - Planning and Quality Assurance).

[26] S.C. Department of Social Services, Unpublished report generated December 2010, CPS Investigations during SFY2010, (Data from DAPSS on August 31 - Planning and Quality Assurance).

one child, these 6,705 findings concluded that 12,321[27] children suffered abuse or neglect. The most common types of maltreatments found in these cases during 2009-2010:

1. "Neglect" or "Threat of Harm for Neglect" was found 8,812 times.[28] Neglect occurs when children are not cared for properly and may go hungry, injure themselves due to lack of supervision, and/or do not receive the medical, educational, or emotional attention needed.
2. "Threat of Harm for Physical Abuse" was found 2,869 times.[29] This occurs when a child is at imminent risk of being physically abused.
3. "Physical Abuse" was found 1,501 times.[30] This occurs when the parent or person responsible for the child's well-being permits or inflicts physical injury.

Child abuse victims include those children who suffer trauma as they witness their siblings being abused. Approximately one-half of child abuse victims are five years old or younger.[31] Although child maltreatment occurs across all socioeconomic levels, it is more likely to occur when parents are under great stress, such as financial burdens, have addictions to substances, have histories of maltreatment themselves, are isolated without support systems, and where spousal abuse is present.[32] Children with disabilities are more likely to be abused or neglected.[33]

The State takes custody of the children it removes from their homes to ensure their protection. The ensuing placement in foster care is costly and may result in further trauma to the children caused by the fear and anxiety of being separated from their families. Children who remain in foster care for extended periods of time experience anxiety and depression as they wait indefinitely for some sense of permanency in their lives. Over 8,000 children lived in an out-of-home placement for protection from abuse or neglect during 2009-2010; there were approximately 5,000 children living in foster care at any given time.[34] During that year:

1. According to the Foster Care Review Board, there were 3,509 admissions of children into foster care, of which 708 had previously lived in foster care.[35]
2. Over 4,000 children exited foster care. Of those children, 1,942 were returned to their families, 1,035 were placed with relatives, 533 were adopted, and 426 aged out of care or were emancipated.[36]
3. There were 8,373 children who lived in foster care for some amount of time.[37]

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[27] S.C. Department of Social Services, Children in Founded Investigations during SFY 09-10 based on Determination date. Children in Founded CPS Investigations During , https://dss.sc.gov/content/library/statistics/cw/reports.aspx?ID=108 (last visited January 17, 2011).
[28] S.C. Department of Social Services, Maltreatment Types Founded in CPS Investigations during SFY 09-10, DSS Planning and Quality Assurance https://dss.sc.gov/content/library/statistics/cw/reports.aspx?ID=108 (last visited on January 18, 2011).
[29] S.C. Department of Social Services, Maltreatment Types Founded in CPS Investigations during SFY 09-10, DSS Planning and Quality Assurance https://dss.sc.gov/content/library/statistics/cw/reports.aspx?ID=108 (last visited on January 18, 2011).
[30] S.C. Department of Social Services, Maltreatment Types Founded in CPS Investigations during SFY 09-10, DSS Planning and Quality Assurance https://dss.sc.gov/content/library/statistics/cw/reports.aspx?ID=108 (last visited on January 18, 2011).
[31] S.C. Department of Social Services, Children in Founded CPS Investigations During SFY 09-10 based on Determination Date, https://dss.sc.gov/content/library/statistics/cw/reports.aspx?ID=108 (last visited January 17, 2011)..
[32] U.S. Department of Health and Human Services, Administration for Children and Families, http://www.childwelfare.gov/pubs/usermanuals/foundation/foundatione.cfm (last visited January 6, 2011).
[33] U.S. Department of Health and Human Services, Administration for Children and Families, http://www.childwelfare.gov/pubs/usermanuals/foundation/foundatione.cfm (last visited 1/6/11).
[34] S.C. Department of Social Services, unpublished report generated December 2010. Ages of Children Served in Foster Care by Office During FY 09-10 unpublished report generated December 2010.
[35] South Carolina's Children Foster Care Review Board, 2009-2010 Annual Report and Recommendations: Promoting Permanence through Partnership, 2010.
[36] S.C. Department of Social Services, Child Welfare Services in State Fiscal Year 2009-2010 , unpublished report generated December 2010.

4. The average length of stay in foster care for all children was 17 months.[38] The average stay in foster care for children who returned to their parents was about 8 months. For children waiting adoption, the average stay was 40 months; and, for children who aged out of the system, the average stay was 54 months.[39] Children ages birth through five were the most prevalent age group in foster care.[40]

For most children removed from their homes, family foster care is the preferred setting. Foster care relies on individuals and families willing to take these at-risk, troubled children into their own homes and provide them with nurturance and support. The State has the legal custody of the children it removes from their families, and the State is responsible for the child's support and welfare. The State reimburses foster parents a monthly average of $372 [41] per child in payment of child support, which is roughly one-half of the minimally needed amount. Recruitment and training of foster homes is critical. The inadequate number of foster care homes means that some children are placed in institutional settings or foster homes based on the availability of a placement rather than the needs of the child; such placements lead to placement disruptions and multiple moves of the child within the foster care system. Children who have lived in foster homes often report feelings of fear, anxiety, depression, and frustration resulting from their circumstances.[42]

Of the approximately 2,000 children who exited foster care during 2009-2010, more than 1,300 scored below the basic score on the English portion of the PACT test[43], and over 1,500 scored below the basic score on the Math section.[44] Also, approximately 131 of children who aged out of the foster care system or were emancipated were arrested within two years.[45] There were 109 referrals to DSS of alleged abuse or neglect of children while living in foster care placements; 5 of these referrals were ultimately indicated for cases of neglect or abuse.[46]

For abused and neglected children with more significant emotional and mental health related needs, there has been an increasing reliance on the Intensive Foster Care and Clinical Services (IFCCS) division of DSS and specialized therapeutic placements in recent years. During 2009-2010:

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[37] S.C. Department of Social Services, unpublished report, Key Stats from Child Welfare Services, December 2010. This number represents the total number of children for the fiscal year. At any point in time, there may be 5,000 children in Foster Care.
[38] S.C. Department of Social Services, Foster Care – Average Months in Care for Children Who Left Foster Care During Fiscal Year, https://dss.sc.gov/content/library/statistics/cw/FCAverageMonthsInCareHistory.pdf (last visited January 18, 2011).
[39] S.C. Department of Social Services, Child Welfare Services in State Fiscal Year 2009-2010 , unpublished report generated December 2010.
[40] S.C. Department of Social Services, unpublished report generated December 2010. Ages of Children Served in Foster Care by Office During FY 09-10 unpublished report generated December 2010.
[41] Adoption.com, Foster Care Rates, South Carolina, http://www.fosterparenting.com/foster-care/foster-care-rates.html (last visited January 18, 2011).
[42] S.C. Department of Social Services, Who Are Our Children in Foster Care?, https://dss.sc.gov/content/library/statistics/cw/FosterCareBrief.pdf (last visited January 18, 2011).
[43] Children Come First, Facts About Foster Care, http://www.scchildrencomefirst.org/ccf/facts-about-sc-foster-care (last visited January 18, 2011).
[44] Children Come First, Facts About Foster Care, http://www.scchildrencomefirst.org/ccf/facts-about-sc-foster-care (last visited January 18, 2011).
[45] Children Come First, Facts About Foster Care, http://www.scchildrencomefirst.org/ccf/facts-about-sc-foster-care (last visited January 18, 2011).
[46] S.C. Department of Social Services, unpublished report generated October 2010, Out of Home Abuse and Neglect Unit.

1. 2,268 children were identified by local interagency staffing teams to be in need of placement and being so severely emotionally or behaviorally disturbed that they could not function effectively in their parental homes or in regular foster home care.[47]
2. However, due to limited resources, IFCCS could provide intense case management and support services for only 1,401 of these children in therapeutic placements.[48]
3. Those therapeutic placements included[49]:

    a. 265 children in residential treatment facilities,
    b. 124 children in high management group homes,
    c. 73 children in moderate management homes,
    d. 906 children in therapeutic foster homes, and
    e. 33 children in supervised independent living.

Foster care is not desired as a permanent solution, and 747 of the children living in foster care last year did return home to their families. However, many children live far too long in foster care; the average length of stay for a child entering foster care was 17 months.[50] In 2009, the 533 children who left foster care through adoption had lived in an average of 2 foster care homes and spent an average of almost 3.5 years total in the system.[51] Currently, approximately 1,600 children have a plan for ultimate adoption; of these, 978 await the legal termination of their parents' rights, and 688 are already legally free and awaiting adoption.[52] Over 400 of these 1,600 children are older than 13 years and have lived in foster care an average of 5 years.[53] [54] In 2009-2010 there were 426 adoptable children who reached age 18 and aged out of foster care without experiencing the encouragement and guidance of a permanent family.[55] Those children will be more likely to live in poverty.[56] Nationally, 12% of all youth who age out of foster care report being homeless at some point after leaving foster care; in South Carolina that would compute to some 48 foster children a year eventually becoming homeless.[57]

Adoption will not occur for all eligible foster children, and when it does, on average it takes 40.7 months for the adoption process to be completed; the goal of DSS, and associated federal

[47] S.C. Department of Social Services, Emotionally or Behaviorally Disturbed Children Deemed ISCEDC Eligible and in Need of a Therapeutic Placement, https://dss.sc.gov/content/library/statistics/cw/ISCEDCEligibleYouthbyFY.pdf (last visited January 18, 2011).
[48] S.C. Department of Social Services, Intensive Foster Care and Clinical Services Placements by Levels of Care for Fiscal Year 09-10, https://dss.sc.gov/content/library/statistics/cw/IFCCSPlacementsByLevelOfCare.pdf (last visited January 18, 2011).
[49] S.C. Department of Social Services, Intensive Foster Care and Clinical Services Placements by Levels of Care for Fiscal Year 09-10, https://dss.sc.gov/content/library/statistics/cw/IFCCSPlacementsByLevelOfCare.pdf (last visited January 18, 2011).
[50] S.C. Department of Social Services, Foster Care – Average Months in Care for Children Who Left Foster Care During Fiscal Year, https://dss.sc.gov/content/library/statistics/cw/FCAverageMonthsInCareHistory.pdf (last visited January 18, 2011).
[51] S.C. Children's Foster Care Review Board, Office of the Governor, Office of Executive Policy and Programs, unpublished report, July 1, 2009-June 30, 2010, report run October 27, 2010.
[52] S.C. Department of Social Services, Children Waiting for Adoption. https://dss.sc.gov/content/library/statistics/cw/ChildrenWaitingforAdoption.pdf (last visited January 24, 2011)
[53] S.C. Department of Social Services, Children Waiting for Adoption. https://dss.sc.gov/content/library/statistics/cw/ChildrenWaitingforAdoption.pdf (last visited January 24, 2011)
[54] South Carolina's Children Foster Care Review Board, 2009-2010 Annual Report and Recommendations: Promoting Permanence through Partnership, 2010.
[55] South Carolina's Children Foster Care Review Board, 2009-2010 Annual Report and Recommendations: Promoting Permanence through Partnership, 2010.
[56] MacArthur Foundation Research Network on Transitions to Adulthood and Public Policy, Policy Brief April 2005, Issue 19, http://www.transad.pop.upenn.edu/downloads/courtney--foster%20care.pdf (last visited January 18, 2011).
[57] MacArthur Foundation Research Network on Transitions to Adulthood and Public Policy, Policy Brief, April 2005, Issue 19, http://www.transad.pop.upenn.edu/downloads/courtney--foster%20care.pdf (last visited January 18, 2011).

guideline, is 24 months.[58] Legal guardianship of a child by a relative or other person can be a preferred option for a child who cannot return home. Though not permanent, legal guardianship is recognized by the family court and gives the guardian certain limited powers to act on behalf of the child, such as school enrollment or health care. Currently, legal guardianship is under-utilized in South Carolina due to the lack of financial support and other services for the child and the guardian. A child placed in legal guardianship may be eligible for Medicaid; however, additional financial support is limited to those children eligible for TANF.

DSS has partnered with DJJ and DMH to serve abused and neglected children who are determined to have overlapping needs. DMH assists with mental health evaluations of children who are removed from their homes and placed in emergency protective custody. DSS and DJJ have initiated the "Georgetown Project" to better track and serve those children who crossover from the child welfare system into the juvenile justice system.

Funding losses have left DSS with an inadequate number of child protection case workers and resources needed to investigate abuse, recruit and train foster homes, and to place and supervise children and oversee treatment plans. Since fiscal year 2008, DSS has lost over 500 employees as a result of reductions of $50 million in State funds, plus $72 million in lost federal matching funds.[59]

Given the State's limited resources, to be successful, child welfare and protection efforts must seek to relieve its overburdened child protection and foster care systems with steps which provide enhanced safety for abused and neglected children, more expeditious agency and court processing of cases, and better permanency outcomes for children in foster care. To achieve these goals will require improved, streamlined case management and enhanced capabilities and competency of foster care. The impacts of both short and long range costs must be considered.

Some children enter the system from families experiencing first time problems; others come from multi-generational families involved in child protection and foster care. Methods to improve "Family Preservation" should include evidenced-based programs designed to quickly focus on and resolve specific family problems, emphasis on faith-based initiatives, and more consideration given the prevalence of alcohol and drug abuse within families in child protection cases.

The high stress of dealing with child abuse coupled with the low employment benefits experienced by child protection caseworkers results in a high turnover of these staff. The position of a child protection caseworker should be sufficiently desirable to attract and retain qualified, capable, compassionate staff, and they must be provided with relevant training and assigned reasonable-sized caseloads. Foster parents require training, effective case management, financial support, community integration, and should be accountable. The processing of child protection, foster care, termination of parental rights, and adoption cases within the family courts needs sufficient attorney and judicial resources and options (such as alternative family mediation programs) to allow timely and thoughtful consideration.

[58] South Carolina's Children Foster Care Review Board, 2009-2010 Annual Report and Recommendations: Promoting Permanence through Partnership, 2010.
[59] S. C. Department of Social Services, Budget and Control Board Postpones Action on Request to Recognize the DSS Deficit, https://dss.sc.gov/content/about/news/story.aspx?StoryID=177 (last visited January 18, 2011).

Protection and family re-unification, or other permanent placement for abused and neglected children must be achieved. Often these children are multi-agency clients, and the child caseworkers and services of DSS frequently overlap with those of DJJ and DMH. It is important to promote the collaboration and interaction of these agencies' programs.

B. Juvenile Justice:

DJJ provides the intake, supervision, and programs for juveniles who are referred to the local family courts for some type of delinquent behavior. Most of these juveniles are referred for relatively minor and non-violent offenses. Generally, these youth come from backgrounds of low income; they have learning disabilities and poor school performance, emotional and mental disorders, and family dysfunctions which may include abuse or neglect. The goals of juvenile justice are twofold: public safety and redirecting delinquent youth to acceptable behavior, good citizenship, and positive futures.

For most of its clients and programs, DJJ is a child-serving agency which integrates with the missions of DSS, DMH, and the public schools. The vast majority of DJJ clients and services are located in its community-based programs. Annually, DJJ processes some 20,000 cases in the family courts involving over 15,000 children.[60] Family court outcomes for these children result in DJJ having a daily average of some 5,000[61] juveniles being supervised in the community and some 200[62] juveniles incarcerated in long-term commitment. Other juveniles are placed in DJJ's regional evaluation centers, pre-trial detention center, and various alternative community-based programs, such as wilderness camps, marine institutes, and after school centers operated throughout the State. The agency relies heavily on volunteers and mentors to assist in its programs.

Our juvenile justice system must be aligned with both public safety interests and with treatment goals for the child. Although there is some overlap, in the broadest sense DJJ deals with two types of children: violent and non-violent. Those who are violent need to be identified, closely monitored, and incarcerated or intensely supervised while being rehabilitated; these youth are more likely to be incarcerated. Most children involved with DJJ are non-violent and have either responded inappropriately to some circumstance or have simply acted immaturely. The vast majority of these non-violent children have the potential to develop the life skills needed to become productive citizens.

Over one-half of the children incarcerated at DJJ are there for minor, non-violent offenses; and, the majority of them have a diagnosable mental health condition or a learning disability. Many of these children are victims of parental neglect and abuse, and they have learned to react to stress with poor judgment and impulsive anger. Evidence shows that their rate of re-offending drops significantly when these non-violent children are treated as youth who need guidance and

[60] S.C. Department of Juvenile Justice, Annual Report Card 2008-2009, http://www.state.sc.us/djj/pdfs/2008-Report-Card.pdf (last visited January 18, 2011).
[61] S.C. Department of Juvenile Justice, 2009-2010 Annual Statistical Report, http://www.state.sc.us/djj/pdfs/2010%20Annual%20Statistical%20Report.pdf (last visited January 18, 2011)
[62] S.C. Department of Juvenile Justice, Plan for Continuing Juvenile Justice Reform in South Carolina: 2011-2015, Draft generated October 4, 2010

training, and are placed in more successful, less expensive community-based programs (such as DJJ's intensive supervision, wilderness camps, and marine institutes).[63] [64] To simply prosecute and incarcerate such children and ignore their underlying issues places them on an assembly line that can manufacture adult criminals.

The life skills these children lack commonly include the ability to learn and perform in school, to have successful interpersonal relationships, to understand and respect the rights of others, and to obtain and retain a meaningful job. There are proven, evidence-based techniques which successfully address the learning disabilities, anger, anxiety, and depression that these children experience. DJJ represents the best, and sometimes last, good chance to redirect these lives away from an adult lifetime of costly dependency on the State for welfare, social services, and corrections.

During the 1990's, DJJ was mired in federal litigation regarding the conditions of its overcrowded long-term institutions. In response, the General Assembly funded community-based alternatives to the institutions, and hundreds of children were transferred out to a statewide network of wilderness camps and marine institutes (six month residential programs focused on life skills training and obtaining a GED). As a result, the institutional conditions improved, and the lawsuit was settled in 2003. The lawsuit did not simply reduce the institutional population, but rather it transferred non-violent children to beneficial life-skill programs with excellent success rates. DJJ has added local Intensive Supervision Probation Officers (ISOs) who are assigned a maximum of 20 juveniles to intensely supervise. If current economic conditions are permitted to eliminate successful community-based alternatives, the State would be in jeopardy of returning to the institutional conditions of the 1990's. DJJ institutional beds cost $300 per day, compared to $100 per day for wilderness camp and marine institute beds and $7.40 per day for intensive community supervision.[65] Programs such as juvenile arbitration which divert juvenile cases away from court intervention are very successful and cost less than $2 per day. With these steps, DJJ has reduced both its cost of operations and statewide juvenile incarceration rates.

Of the some 20,000 cases referred to DJJ last year, 18,187 were for non-violent offenses: disturbing schools; simple assault and battery; shoplifting; public disorderly conduct; simple possession of marijuana; truancy; and for violations of probation for misdemeanors, simple assault, contempt of court, and petty larceny.[66] Only 1,813 referrals were for felonies and violent offenses: offenses classified as acts against person (except non-aggravated assaults such as simple assault and battery), arson 1st and 2nd degree, burglary 1st and 2nd degree, and drug trafficking.[67] Violent and serious juvenile crime has declined by 49 percent since the peak

[63] AMIKids, 2010 AMIKids State Stats, http://www.amikids.org/Default.aspx
[64] S.C. Department of Juvenile Justice, Plan for Continuing Juvenile Justice Reform in South Carolina: 2011-2015 prepared by SCDJJ Office of Planning and Programs, Draft Oct 4, 2010
[65] S.C. Department of Juvenile Justice, Plan for Continuing Juvenile Justice Reform in South Carolina: 2011-2015 prepared by SCDJJ Office of Planning and Programs, Draft Oct 4, 2010.
[66] S.C. Department of Juvenile Justice, 2009-2010 Annual Statistical Report, http://www.state.sc.us/djj/pdfs/2010%20Annual%20Statistical%20Report.pdf (last visited January 18, 2011).
[67] S.C. Department of Juvenile Justice, unpublished report generated December 2010, Narrative Explanations and Input for the Children's Law Center Data Request for a Profile of Children Served in South Carolina's Juvenile Justice System.

period of the mid 1990's; referrals for violent and serious juvenile crimes have declined from some 3,600 cases in 1994-1995 to 1,700 cases in 2009-2010.[68]

One strength of our family courts is their breadth of sentencing options which can be tailored to the individual circumstances and needs of each juvenile. In 2009-2010, a total of 1,977 juveniles were committed to a DJJ long-term correctional institution. In the same year, 75% of the family court sentences were for short-term, determinate periods of 90 days or less. The resulting average daily population was approximately 200 juveniles. The remaining 25% of sentences for more serious offenses were for an indeterminate period of time with the juvenile's date of release to be determined by the Juvenile Parole Board. Other types of short-term commitments in DJJ facilities include temporarily placement in the agency's pre-trial detention center and in its regional evaluation centers. Last year, 3,887 juveniles were placed in the DJJ pre-trial detention center for an average length of stay of 11 days; 236 juveniles were placed in the DJJ residential evaluation centers for an average length of stay just under 40 days.[69] Last year, 371 juveniles were placed in wilderness camps, marine institutes, and foster homes. By agreement with DMH, DJJ transfers to DMH those seriously mentally ill juveniles who are committed to DJJ.

Program success rates and the cost of services direct that the State sort juvenile offenders by the risk they present and then place and serve them accordingly. Only 1,813 of the total 20,394 cases (approximately 9%) referred in 2009-2010 were for violent offenses.[70] Clearly, juveniles who are violent or dangerous should be intensely supervised or locked up. However, non-violent juveniles generally do not need long-term incarceration, and they should not be housed with violent offenders. Incarcerating a child who is acting out or hard-to-place with violent offenders may be convenient at the moment; but if done repeatedly statewide, the collective long term result would be an increase in crime, more unnecessary victims, added cost to the State, and loss of human potential.

DJJ has now lost 29% (28 million dollars) of its budget, closed its five group homes and a wilderness camp, and reduced or eliminated many community programs. Sustaining community based services is the State's key to allowing meaningful choices in sentencing juveniles. These community based services have already been shown to: lower crime rates, result in fewer victims, produce better behaving youth, keep non-violent youth out of institutions, and maintain the State's compliance with the Federal Court Order resulting from the lawsuit settled in 2003.

There is a disproportionately high number of minority youth in juvenile justice. While some 2/3 of the youth incarcerated at DJJ are minority children, only 1/3 of the children living in South Carolina are minority.[71] Community-based programs are the essential alternatives which address this issue.

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[68] S.C. Department of Juvenile Justice, unpublished report generated December 2010, Narrative Explanations and Input for the Children's Law Center Data Request for a Profile of Children Served in South Carolina's Juvenile Justice System.

[69] S.C. Department of Juvenile Justice, 2009-2010 Annual Statistical Report, http://www.state.sc.us/djj/pdfs/2010%20Annual%20Statistical%20Report.pdf (last visited January 18, 2011).

[70] S.C. Department of Juvenile Justice, Juvenile Justice Report Card 2010. http://www.state.sc.us/djj/pdfs/2010%20report%20card-final.pdf (last retrieved January 25, 2011).

[71] Children's Law Center, Disproportionate Minority Contact (DMC), Community DMC Reduction Initiative, http://childlaw.sc.edu/dmc.asp (last visited January 18, 2011).

Access by children to the effective assistance of counsel is critical to the process of individual case advocacy. An effective public defender can identify a child's problems and needs to the court and urge meaningful treatment alternatives to prosecution and incarceration.

"Disturbing schools" has become the most frequent juvenile offense in South Carolina. The increased prosecution for disturbing schools is not a reflection of increased crime at school, but rather the formal case processing that results when law enforcement is tasked to handle routine, adolescent behavior problems. A juvenile who commits serious misconduct or violence at a school can be prosecuted under other relevant criminal statutes without resort to a charge of "disturbing schools." Relying on the charge of disturbing schools (which is statutorily defined as a student with "obnoxious behavior" on school grounds)[72] for minor misconduct can unnecessarily push non-violent children with mental and learning disorders into the juvenile justice arena.

Nearly 4,000 children were picked up and held in DJJ's pre-trial detention center in 2010. While approximately 60% of these children were charged with non-violent offenses, less than 10% of them were ultimately committed to DJJ.[73] Pre-trial detention is often used for reasons other than public safety, (e.g. when their parents cannot be found). Further investigation into the underlying issues of a child's misconduct can lead to a more appropriate and less costly placement. Ideally, the pre-trial incarceration of a juvenile should occur only when the juvenile presents a threat to public safety or a risk of flight from the court.

C. Children's Mental Health:

Children with an untreated mental disorder will carry that problem into each stage of their adolescence -- and ultimately into their adulthood. As a child ages into school, the learning process and expanded social interactions will place increasing demands on them. According to the National Survey of Children's Health, approximately 25,000 children in South Carolina did not receive a needed mental health service in 2007.[74] For many such children, their needs are simply overlooked and unresolved. This path can be undermined by anxiety and depression, and thousands will fail, drop out of school, turn to alcohol or drugs, become delinquent, and proceed to lives of costly dependency on the State in the forms of welfare, social services, public heath care, and corrections. Our public schools and child service agencies must be vigilant to detect and respond to those individual child behaviors which are key indicators of emerging mental health issues.

The Department of Mental Health (DMH) served 30,422 children during 2009.[75] Over half of all child and adolescent clinical contacts with DMH are with seriously emotionally disturbed children.[76] The prevalence of children with major depressive episodes is staggering; according

[72] S.C. Code Ann. §16-17-420.
[73] S.C. Department of Juvenile Justice, unpublished report generated December 2010, Narrative Explanations and Input for the Children's Law Center Data Request for a Profile of Children Served in South Carolina's Juvenile Justice System.
[74] National Survey of Children's Health, Search Data Sets, 2007 NSCH, Child Health Measures, South Carolina, Healthcare Access and Quality, Received Needed Mental Healthcare, http://nschdata.org/Content/Default.aspx (last visited January 18, 2011).
[75] S.C. Department of Mental Health, Annual Statistical Report, Fiscal Year 2009-2010, http://www.state.sc.us/dmh/09_accountability_report.pdf (last visited January 18, 2011). Compilation provided by SCDMH.
[76] S.C. Department of Mental Health, Accountability Report, Fiscal Year 2009, http://www.state.sc.us/dmh/09_accountability_report.pdf (last visited October 22, 2010).

to the National Substance Abuse and Mental Health Services Administration, an estimated 31,000 children in South Carolina aged 12 to 17 had a major depressive episode in the past year.[77] DMH data show an increase in children and adolescents with major mental illness. From a baseline year of 2001, 41% of all child and adolescent contacts by DMH had a major mental illness; however, by 2010 that percentage of children with a major mental illness climbed to 51%.[78] The actual number of clients remained relatively constant at approximately 30,000 children.[79] As the economic climate forces difficult choices of how to serve more children with fewer resources, it is imperative that front-end treatment options, such as school based programs and early intervention practices, remain intact.

Whether a child's mental health issue is temporary or will be a life-long condition, these are children whose lives can be improved by greater access to mental health diagnosis and treatment. Regular, sustained mental health services such as those at community mental health centers and school-based programs may reveal circumstances of child abuse or neglect within the family, treatable depression, or other problems which can be successfully resolved at the onset. Missed opportunities to address children's mental health issues have serious financial and social consequences. As an undiagnosed or untreated child grows older, the options of early intervention and community-based counseling are gradually replaced with the realities of school dropout, increased need for public services and support, and expensive institutional treatment or incarceration.

Mental health services must be integrated into all other services for children. The State should create a network within its agencies that cooperatively identifies children in need and shares programmatic efforts.

While it has operated under increasing fiscal constraints, DMH has provided out-of-home placements for children with greatest mental health needs:

1. During 2009- 2010, there were 457 severely mentally ill children treated inpatient at the DMH Hall Institute facility for children and adolescents.[80]
2. As a result of DMH efforts to reduce the reliance on the use of out-of-home placements, the number of children housed statewide in psychiatric residential treatment facilities and therapeutic foster homes declined over the last year from a previous average daily population of 164 children to an average daily population of 107 children.

DMH has successfully partnered with other agencies to serve children with multiple agency needs. Its partnership with the Department of Education allows for shared funding and efficient treatment for children in rural communities who would not otherwise have access to treatment. These school based programs and other primary interventions are effective and have contributed

[77] Substance Abuse and Mental Health Services Administration, Office of Applied Statistics, National Survey on Drug Use and Health, 2006 and 2007, Having at Least one Major Depressive Episode in Past Year, children age 12 to 17 http://www.oas.samhsa.gov/2k7state/ageTabs.htm (last visited October 27, 2010).
[78] S.C. Department of Mental Health, unpublished report, Children and Adolescents with Major Mental Illness, Fiscal Year 2009-2010, Figure 2. Compilation provided by SCDMH.
[79] S.C. Department of Mental Health, unpublished report generated December 2010, A Numerical Profile of Youth Served by DMH SFYs 2003-2010.
[80] S.C. Department of Mental Health, Annual Statistical Report, Fiscal Year 2009-2010, http://www.state.sc.us/dmh/09_accountability_report.pdf (last visited January 18, 2011). Compilation provided by SCDMH.

in part to the decline of children being placed in inpatient psychiatric treatment facilities.[81] Through its partnership with DJJ, DMH also provides services to seriously mentally ill youth committed to DJJ. These juveniles with mental illnesses are transferred from DJJ into DMH residential programs. Approximately one-half of the youth served in the Hall Institute are juvenile delinquents.[82]

Historically, mentally ill juveniles have remained in the DJJ pre-trial detention center for an average of 39 days, compared to other juveniles whose average stay was only 16 days. DMH partnered with DJJ to embed a mental health professional within the DJJ detention center to facilitate mental health examinations and treatment plans for juveniles with mental disorders.[83] Through this collaboration, DMH and DJJ reduced the average length of stay for juveniles with mental illness in the costly detention center from 39 days to only 19 days.[84]

DMH has partnered with DSS in an effort to address the mental health needs of children experiencing the trauma of abuse, neglect, and removal from parental home. When a child is taken into its emergency protective custody, DMH ensures that the child receives a mental health consultation within 24 hours.[85] This partnership includes locating mental health practitioners in twelve DSS county office sites (Anderson, Pickens, Newberry, York, Charleston, Beaufort, Orangeburg, Calhoun, Florence, Sumter, Cherokee, and Horry counties). DMH and DSS also collaborate in case assessments through the Interagency System of Care for Emotionally Disturbed Children (ISCEDC) to determine whether a therapeutic placement is the most appropriate setting for a child.[86]

Also, DMH has partnered with First Steps and with DHEC to provide early assessment and mental health intervention services for young children. In 2009, DMH saw 1,551 children ages 5 and under in its Community Mental Health Centers,[87] and a total of 13,950 children in the 405 public schools with DMH mental health programs.[88] With funding reductions, the DMH school-based programs now operate in fewer schools with fewer staff.[89] Accordingly, there has been a quantitative decrease in the accessibility and frequency of quality interventions for children; this is particularly the case in rural areas where diminishing resources have impacted the waiting time for services.[90]

Thus far, DMH has attempted to protect its services for children and adolescent from more severe cuts. However, this could change dramatically if further budget reductions are compounded by losses of Medicaid funding. Any such dramatic losses in child and adolescent programs would have significant impacts on the above services DMH has been able to provide by its collaboration with other child-serving agencies.

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[81] S.C. Department of Mental Health, meeting with DMH specialists 1/5/11.
[82] S.C. Department of Mental Health, meeting with DMH specialists 1/5/11.
[83] S.C. Department of Mental Health, unpublished report, information provided by SCDMH in response to data request January 2011.
[84] S.C. Department of Juvenile Justice, unpublished report, Detention Center Mental Health Liaison, Grant Review 4/1/07 – 3/31/10.
[85] S.C. Department of Mental Health, unpublished report generated December 2010, A Numerical Profile of Youth Served by DMH SFYs 2003-2010.
[86] S.C. Department of Mental Health, unpublished report generated December 2010, A Numerical Profile of Youth Served by DMH SFYs 2003-2010.
[87] S.C. Department of Mental Health, unpublished report generated December 2010, A Numerical Profile of Youth Served by DMH SFYs 2003-2010.
[88] S.C. Department of Mental Health, unpublished School Based Programs Fiscal Year 2009-2010 Outcome Report.
[89] South Carolina Appleseed Legal Justice Center, Focus on Kids, The Children's Budget Behind the Numbers, Devastating Budget Cuts and Their Impact on the Lives of South Carolina's Children, January 2010.
[90] S.C. Department of Mental Health, unpublished report, information provided by SCDMH in response to data request January 2011

III. Issues Related to a Healthy Childhood in South Carolina:

A. General Overview of South Carolina's Children in Need:

Since the inception of *Kids Count* Data Book, South Carolina has consistently ranked among the bottom eight states in the nation in its comparative assessment of the well-being of its children.[91]

The current economic recession has significantly reduced state and local services for children and their families. Likewise, increases in unemployment, rising poverty, home foreclosures, and loss of health insurance coverage have exacerbated many families' problems and profoundly reduced their ability to cope with the needs of their children. As a result, the problems of children are at an increasingly greater risk to be overlooked or go untreated.

During the 2011 legislative session, the main impacts on children will likely come from budget decisions. As programmatic cuts are incurred by each individual child-serving agency, it is imperative to carefully examine the impact across the board to the programs of the other child-serving agencies.

In South Carolina, many children face extraordinary circumstances which can negatively impact their development and family stability. Among these youth, literally tens of thousands of them:

- live in poverty
- need access to health care
- are abused and neglected
- drop out of school
- are placed in foster care
- suffer mental illness or physical disability
- are sexually active
- experience teen pregnancy
- join gangs
- are referred to the courts for delinquent behavior, and
- have multiple problems and are served by multiple agencies

In the annual *Kids Count Data Book* rankings published by the Casey Foundation since 1990, South Carolina's standing of child well-being among the states has ranged from 42nd to 48th. Our State's low ranking does serve notice that we can and should provide better protection and support for children as they develop into adults. It is in everyone's best financial and ethical interests to promote nurturing families for all children and the development of meaningful, successful life skills for those children at risk and in need.

South Carolina is home to over 1,089,000 children under the age of 18; literally, approximately 1 in 4 citizens of South Carolina is a child.[92] Of these children, approximately: 311,020 are less than 5 years old; 298,000 are between the ages of 5 and 9; 287,000 are aged 10 through 14; and

[91] Annie E. Casey Foundation, Kids Count Data Center, Data Across States, http://datacenter.kidscount.org/data/acrossstates/Rankings.aspx?ind=137 (last visited January 18, 2011).
[92] South Carolina Kids Count, 2009 South Carolina Kids Count Report, http://www.sckidscount.org/kc09.php?COUNTYID=47 (last visited January 18, 2011).

193,000 are between the ages of 15 and 17. [93] Children face a number of challenges which impact their individual futures and, in turn, the future well-being of South Carolina. It is necessary to understand stages of child development, cultural issues, and the economic climate as we shape the policy and delivery of children's services across our State.

B. Family Life:

1. **Demographics**: In 2009, there were 415,829 children (32%) living in single parent families.[94] Divorce, teen pregnancies, and increased births to single mothers account for this increasing number. In 2007, South Carolinians filed 13,233 divorce decrees involving 10,417 children.[95] Also in that year, there were some 29,000 births to single mothers, which constituted 46.4% of all babies born.[96] Children in single parent families are vulnerable to poverty and other burdens when extended family and other supporters are unavailable to assist in caregiving.

2. **Family Violence:** In South Carolina, 31 women were murdered as a result of domestic violence in 2009.[97] While domestic abuse and family violence go largely unreported, South Carolina ranks ninth in the nation for men who murder women. Domestic violence is the leading cause of injuries to women aged fifteen to forty-four (more frequent than auto accidents, mugging, and cancer combined). Children are traumatized both directly as victims of family violence, and indirectly as they witness their mothers and siblings being abused.[98] While it is difficult to determine with certainty how many of the 31 women were murdered by habitual abusers, national research indicates that domestic violence resulting in death is the typically result of an established and pervasive pattern of abuse. [99]

3. **Teen Pregnancy:** In 2009, 2,289 girls aged 12 through 17 gave birth.[100] During the period of 2003 through 2006, 10% of all pregnancies statewide were to children aged 17 and younger.[101]

4. **Drug, Alcohol and Tobacco Use:** While 8,338 children received treatment for drug or alcohol addiction in 2009-2010, the Department of Alcohol and Other Drug Abuse Services (DAODAS) estimates that approximately 18,518 of South Carolina's children needed such

[93] S.C. Department of Health and Environmental Control, http://scangis.dhec.sc.gov/scan Population Statistics Table generated on January 18, 2011, Population Statistics for Residents of South Carolina by Age and Year.
[94] Annie E. Casey Foundation, Kids Count Data Center, Data Across States, Children in single-parent families by race, http://datacenter.kidscount.org/data/acrossstates/Rankings.aspx?ind=107 (last visited January 18, 2011).
[95] S. C. Kids Count, 2009 South Carolina Kids Count Report, http://www.sckidscount.org/kc09.php?COUNTYID=47# (last visited January 18, 2011).
[96] S.C. Kids Count, 2009 South Carolina Kids Count Report, http://www.sckidscount.org/kc09.php?COUNTYID=47# (last visited January 18, 2011).
[97] S.C. Coalition Against Domestic Violence & Sexual Assault, http://www.sccadvasa.org/domestic-violence-facts-and-stats/prevalence-of-domestic-violence.html (last visited January 18, 2011).
[98] S.C. Coalition Against Domestic Violence & Sexual Assault, http://www.sccadvasa.org/domestic-violence-facts-and-stats/overview-of-domestic-violence.html (last visited January 18, 2011).
[99] Washington State Coalition Against Domestic Violence, Advocates and Fatality Reviews, http://www.ncdsv.org/images/Advocates_and_Fatality_Reviews_704.pdf (last visited January 31, 2011).
[100] S.C. Department of Health and Environmental Control, Division of Biostatistics, PHSIS, unpublished report generated December 2010, Number of Births to SC Women age < 18, 2005-2009.
[101] S.C. Department of Health and Environmental Control, At-A-Glance: South Carolina Teen Pregnancy, Pregnancy Risk Assessment and Monitoring System. http://www.scdhec.gov/co/phsis/biostatistics/prams/SC_PRAMS_Teen_Preg_FS.pdf (last visited February 8, 2011).

treatment services.[102] Tobacco use is linked to a number of chronic and costly diseases. Annually in our state, over 23,000[103] children will try cigarettes, and 6,300 of these children will become regular daily smokers.[104] Second-hand smoke affects 240,000 children who are exposed at home.[105] There are currently 103,000 children living in South Carolina who will ultimately die from smoking and smoking related illnesses.[106]

5. **Child Deaths:** There were a total of 788 child fatalities in 2008.[107] Of these fatalities, over 500 were infants under the age of one. The leading causes of infant death were congenital malformations, disorders resulting from short gestation, and low birth weight. For children aged one through fourteen, unspecified accidents and malignant tumors accounted for half of the deaths. For children aged 15 through 17, accidents were the most frequent cause of death, and homicide was the second most frequent cause of death.[108] According to data from 2006, there were 14 suicides among children aged 17 and younger.[109]

C. Socioeconomic Status:

1. **Poverty:** 196,803 of all children in South Carolina (almost 20 %) live in a "poor" family, which is defined as a family of four where the household income is less than $21,200 per year. Moreover, 462,644 children (44%) live in families which have some governmentally measured standard of "low-income." [110] Low income is defined as below the amount of twice the level of federal poverty. Poverty permeates all aspects of healthy life and has far-reaching and lasting consequences. Children in poverty have limited access to quality nutrition which impacts physical and cognitive development, are more likely to be victims of crime, perform poorly in school, and require early interventions for special needs. Children at the lowest levels of poverty have the greatest mental health needs; almost 1 in 5 of children in families of poverty have one or more emotional, behavioral, or living conditions.[111]

Approximately 228,000 South Carolinians were out of work as of November 2010; this equates to 10% of the State's workforce.[112] Normally state agencies would be the protective factor to alleviate the strain felt by children and families in need. However, agencies have

[102] S.C. Department of Alcohol and Other Drug Abuse Services, Accountability Report Fiscal Year 2009-2010, http://www.daodas.state.sc.us/documents/FY10%20DAODAS%20Accountability%20Report.pdf (last visited January 18, 2011).
[103] Campaign for Tobacco-Free Kids, http://tobaccofreekids.org/microsites/passthebuck_sc/resources/sctolloftobacco.pdf (last visited January 18,2011)
[104] Campaign for Tobacco-Free Kids, http://www.tobaccofreekids.org/research/factsheets/pdf/0176.pdf (last visited January 18, 2011).
[105] Campaign for Tobacco-Free Kids, http://tobaccofreekids.org/microsites/passthebuck_sc/resources/sctolloftobacco.pdf (last visited January 18,2011)
[106] Campaign for Tobacco-Free Kids, www.tobaccofreekids.org (last visited January 18, 2011).
[107] S.C. Department of Health and Environmental Control, 2008 South Carolina Residence Data http://www.scdhec.gov/co/phsis/biostatistics/an_pubs/IMR2008highlights.pdf (last visited January 18, 2011).
[108] South Carolina Department of Health and Environmental Control, 2008 South Carolina Residence Data http://www.scdhec.gov/co/phsis/biostatistics/an_pubs/IMR2008highlights.pdf (last visited January 18, 2011).
[109] S.C. Department of Health and Environmental Control, South Carolina Violent Death Reporting System 2006 Violent Deaths in South Carolina Data Report. http://www.scdhec.gov/health/chcdp/injury/docs/2006%20NVDRS%20Final%20Report.pdf (last visited on January 28, 2011),
[110]National Center for Children in Poverty, South Carolina Demographics of Low-Income Children, http://www.nccp.org/profiles/state_profile.php?state=SC&id=6 (last visited 11/9/10).
[111] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Survey of Children's Health 2007, http://www.mchb.hrsa.gov/nsch/07emohealth/state/scarolina.html (last visited January 18, 2011). The federal poverty level was $20,650 in 2007.
[112] South Carolina Department of Employment and Workforce, http://dew.sc.gov/documents/lmi-monthly-trends/november_2010.pdf (last visited January 18, 2011).

felt the effects of the economic downturn as well, and families' problems have been exacerbated as agencies have faced decisions of which children they are able to assist.

2. **Indicators of Hunger:** Of all public school students, 327,718 participated in the state subsidized meal program in 2008-2009. Almost one-half of children in public schools received assistance to obtain proper nutrition.[113] Children are eligible to receive services through the Women, Infants and Children's Food Program (WIC); in 2008, DHEC served 84,992 children, and 57,796 breastfeeding mothers of infants and babies under the age of one.[114] Many children under the age of 18 experience hunger daily and their primary access to food is of poor nutritional value.

3. **Medicaid Funded Healthcare for Children:** The Department of Health and Human Services (HHS) currently has a projected budget shortfall of $228 million.[115] Its Medicaid program ensures that the poor and disabled receive basic healthcare. Two-thirds of Medicaid recipients live in working families, but their incomes are too low to afford insurance.[116] As the economy has worsened, the number of children qualifying for Medicaid has increased from 400,000 in August of 2007, to approximately 480,000 children in April of 2010.[117]

   Roughly, for every dollar South Carolina spends on Medicaid, the federal government matches it with three dollars.[118] If the State were to withdraw from Medicaid, it would forfeit all federal reimbursement. In 2009-2010, the federal portion of South Carolina's Medicaid spending was approximately $4.1 billion.[119]

   States may not alter Medicaid eligibility standards to reduce the number of children eligible for Medicaid.[120] However, because it would not affect eligibility, a state may reduce its service provider rates or eliminate certain benefits which the federal government deems to be "optional services." Should South Carolina opt to eliminate certain optional services, it could potentially eliminate the Medicaid payments that are used for targeted case management and inpatient psychiatric hospital treatment, and, therefore, doing so would close the Hall Institute for children.[121]

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[113] S.C. State Department of Education, Quick Facts: Education in South Carolina, https://apps.ed.sc.gov/agency/Accountability/Data-Management-and-Analysis/old/research/documents/QuickFacts-100801-1.pdf (last visited January 18, 2011).
[114] S.C. Department of Health and Environmental Control, Healthy People Living in Healthy Communities 2009, http://www.scdhec.gov/administration/library/ML-006048.pdf (last visited January 18, 2011.
[115] S.C. Department of Health and Human Services, Medicaid Bulletin, December 14, 2010, http://www.dhhs.state.sc.us/Internet/pdf/MedicaidReductionsBULLETIN.pdf (last visited January 18, 2011).
[116] South Carolina Hospital Association, The Many Faces of Medicaid, http://scha.org/medicaid (last visited January 18, 2011).
[117] S.C. Department of Health and Human Services, Medicaid Sustainability Budget Presentation, Monthly Trend of Eligibles by Category http://msp.scdhhs.gov/msp/wp-content/uploads/2010/08/Medicaid%20Sustainabilty%20Budget%20Presentation.pdf (last visited January 18, 2011).
[118] South Carolina Hospital Association, The Many Faces of Medicaid, http://scha.org/medicaid (last visited January 18, 2011).
[119] S.C. Department of Health and Human Services, Deficit Reduction Plan, November 16, 2010, http://msp.scdhhs.gov/msp/wp-content/uploads/2010/09/DHHS-Deficit-Reduction-Plan-11-16-2010.pdf (last visited January 18, 2011).
[120] S.C. Department of Health and Human Services, Deficit Reduction Plan, November 16, 2010, http://msp.scdhhs.gov/msp/wp-content/uploads/2010/09/DHHS-Deficit-Reduction-Plan-11-16-2010.pdf (last visited 1/18/11).
[121] S.C. Department of Health and Human Services, Deficit Reduction Plan, November 16, 2010, http://msp.scdhhs.gov/msp/wp-content/uploads/2010/09/DHHS-Deficit-Reduction-Plan-11-16-2010.pdf (last visited January 18, 2011).

D. Health:

1. **Uninsured Children:** Over 136,000 of South Carolina's children had no health insurance in 2009.[122] Health insurance is essential to treatment for illness, preventive health care, and immunizations. For many children, the school nurse is their only access to health care; thus, school attendance and drop-out are related to health care.

2. **Immunizations:** The most recent, reliable data on childhood immunizations indicate that in 2001, 78% (roughly 42,600) of children had received the CDC recommended dosage of vaccinations by the age of 2.[123] The recommended vaccinations for children at that time, known as the "431331 series" includes: 4 DTaP (Diphtheria and tetanus toxoids and acellular pertussis vaccine); 3 Polio; 1 MMR (Measles, Mumps and Rubella); 3 Hib (Haemophilus influenza type b conjugate vaccine); 3 Hep B (Hepatitis B); and 1 Chicken Pox (Varicella).[124]

3. **Obesity:** Over one-third of all high school students in South Carolina's are obese or overweight.[125] Although somewhat counter-intuitive, access to primarily low quality food can lead to obesity as illustrated by the fact that 25% of South Carolina's low income children ages 2 through 5 are overweight or obese.[126] Research at the University of North Carolina at Chapel Hill recently concluded that obese teenagers not only stay obese, but will also add an average of 80 more pounds as they age into adulthood; this obesity will lead to an increase of diabetes, heart disease, arthritis, and cancer. [127]

4. **Chronic Illnesses:** Various chronic diseases serve as a barometer for a community's public health. Some primary indicators for South Carolina include:

    a. **Asthma:** Asthma is the most common chronic disease and the leading cause of disability among children. An estimated 90,000 children suffer from asthma. Most recent data available from 2008 shows that there were 5,680 hospitalizations among children for asthma and asthma related conditions. In the same year, 24% of public high school students with asthma smoked, and 72%[128] of all high school students with asthma were commonly exposed to the second-hand smoke of others.[129]

    b. **Diabetes:** Type 1 and Type 2 diabetes was diagnosed in approximately 2,000 children in 2007.[130] Diabetes in children is generally attributed to genetics,

[122] U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, Table HI05, South Carolina, Under 18 Years, Not Covered at any time during the year, http://www.census.gov/hhes/www/cpstables/032009/health/h05_000.htm (last visited January 18, 2011).
[123] S.C. Department of Health and Environmental Control, Two-Year Old Immunization Coverage Survey of South Carolina Children 2001, http://www.scdhec.gov/health/disease/immunization/docs/01survey.pdf (last visited January 25, 2011)
[124] [124] S.C. Department of Health and Environmental Control, Two-Year Old Immunization Coverage Survey of South Carolina Children 2001, http://www.scdhec.gov/health/disease/immunization/docs/01survey.pdf (last visited January 25, 2011)
[125] S.C. Department of Health and Environmental Control, Obesity Prevention & Control, http://www.scdhec.gov/health/chcdp/obesity/ (last visited January 18, 2011).
[126] S.C. Department of Health and Environmental Control, Overweight and Obese Children in South Carolina, http://www.scdhec.gov/administration/library/ML-025373.pdf (last visited January 18, 2011).
[127] The State Newspaper, Little Progress Made on Obesity, Section A8, January 15, 2011.
[128] Campaign for Tobacco-Free Kids, http://www.tobaccofreekids.org/research/factsheets/pdf/0176.pdf (last visited January 18, 2011).
[129] S.C. Department of Health and Environmental Control, Asthma in South Carolina, http://www.scdhec.gov/health/epidata/docs/StateAsthma.pdf (last visited January 18, 2011).
[130] National Diabetes Information Clearinghouse, National Diabetes Statistics, 2007 http://www.diabetes.niddk.nih.gov/dm/pubs/statistics/#d_allages (last visited January 18, 2011).

environmental insults to the immune system, and lifestyle habits. Diabetes often goes undiagnosed and untreated. Proper treatment can prevent or delay the onset of complications such as kidney disease, blindness, heart disease, and amputations.[131]

c. **Childhood Cancer:** Childhood cancer was diagnosed in 215 new cases during 2007.[132] That number does not include children previously diagnosed with cancer. In 2007, 12 children died from cancer.

d. **HIV and AIDS:** South Carolina had 181 children living with HIV and AIDS at the end of 2009.[133] During that year, 6,037 children received testing for HIV.[134]

e. **Sexually Transmitted Diseases (STDs):** During 2008-2009, children were diagnosed and treated for approximately 9,816 cases of chlamydia, 2,988 cases of gonorrhea, and 8 cases of syphilis.[135] This total of about 13,000 cases is deemed to be an under-representation of the prevalence of cases due to under-reporting and infected children who go untested and untreated.

E. Education:

1. **Developmental Disorders and Special Needs:** The Department of Education reports that 101,896 children were placed in special education programs in 2007. Conditions ranged from serious to mild learning and behavioral problems.[136] Statewide, there is a large system of self-contained, resource, and itinerant services in which 19,339 children were placed for speech and language impairments; 45,227 for learning disabilities; 4,046 for emotional disabilities; 10,280 for mental impairments; and 13,174 for physical disabilities, deafness, blindness, and other disabilities. Special education classes served approximately 13.1% of all students in grades 1-12 during 2007-2008.[137] Twenty-eight children with profound special needs and developmental delays live in DDSN placement.[138] Additionally, there are approximately 580 children with disabilities who receive essential services in the community and home placements pursuant to eligibility waivers through Medicaid.[139]

DDSN reports serving over 11,000 children with special needs, which includes 8,560 children with intellectual disorders, 2,969 children with autistic spectrum disorder, and 31

[131] S.C. Department of Health and Environmental Control, Diabetes in South Carolina, http://www.scdhec.gov/health/epidata/docs/Diabetes%20Fact%20sheet.pdf (last visited January 18, 2011).
[132] S.C. Department of Health and Environmental Control, http://scangis.dhec.sc.gov/scan/ retrieved 1/4/11. Dataset= Cancer Incidence (1996-2007) and Cancer Mortality (1996-2007). Cancer Incidence Statistical File, South Carolina Residents by year and age.
[133] S.C. Department of Health and Environmental Control, South Carolina's STD/HIV/AIDS Data http://www.scdhec.gov/health/disease/sts/docs/December%202009.pdf (last visited January 18, 2011).
[134] S.C. Department of Health and Environmental Control, People Tested for HIV in South Carolina by Gender, Race/Ethnicity, Age, Site Type, Risk Exposure, and Region http://www.scdhec.gov/health/disease/sts/docs/labqr09.pdf (last visited January 18, 2011).
[135] Center for Disease Control and Prevention, Sexually Transmitted Diseases – Interactive Data 1996-2008 http://wonder.cdc.gov/controller/datarequest/D46;jsessionid=CA08FDAE9BA0F9256A5DBE2E609E2D9A?stage=results&action=toggle&p=O_labels_btn&v=false (last visited January 18, 2011). Tables generated by state, age and Sexually Transmitted Disease.
[136] S.C. State Department of Education, South Carolina's Exceptional Children's Statewide Data Collection History, Child Count, 2008 South Carolina Summary 3-21. http://ed.sc.gov/agency/Standards-and-Learning/Exceptional-Children/OECData/DataCollectionHistory.html (last visited January 18, 2011)
[137] S.C. Kids Count, 2009 South Carolina Kids Count Report, http://www.sckidscount.org/kc09.php?COUNTYID=47#Scholastic (last visited January 18, 2011).
[138] S.C. Department of Disabilities and Special Needs, unpublished report provided by DDSN upon request generated November 2010, SCDDSN Consumers by Age as of 9/30/10.
[139] S.C. Department of Disabilities and Special Needs, meeting with specialists, January 26, 2011

children with head and spinal cord injuries.[140] [141] The State Department of Education reported serving 3,054 children with autistic spectrum disorders during the 2008 school year. The numbers of children served by DDSN may include some overlap with the students served by the State Department of Education.

More children will be diagnosed with autistic spectrum disorders than with AIDS, pediatric cancer and diabetes combined. Many cases of autism are undetected. Research indicates that early identification and treatment of autism can lead to significant improvements in child outcomes and dramatic reductions in the associated cost of care. A recent study concluded that the provision of Early Intensive Behavioral Intervention (EIBI) to children with autism would save $208,500 per child over an 18 year period of special education treatment.[142]

2. **Graduation Rate from High School:** There is a variance among organizations of the data and formulas used to calculate student graduation rates.[143] Calculations by *Kids Count* and by the State Department of Education estimate that between 61% and 74% of students graduate with a diploma. The State Department of Education reported that in the 2007-08 school year, 36,479 students completed requisite coursework and passed end-of-course exams and received a high school diploma.[144] [145] Of those who did complete high school with a diploma, only 39% will enter post-secondary schools.[146] Also during that year, 2,233 students received a state or local certificate for having completed high school.[147] Those certificates of completion are not recognized by colleges or U.S. Military recruiters, but do indicate that the student has completed high school without passing the exit exam required for graduation.[148]

3. **School Drop-out Rates:** Generally, there are two types of school drop-outs reported: "status drop-outs" are students who simply do not return to school, never graduate or complete high school, but also never file formal papers to withdraw; and, "event drop-outs" who are students who formally withdraw from school, and do complete the necessary paperwork to do so.[149] The State Department of Education reports that the school drop-out

[140] S.C. Department of Disabilities and Special Needs, unpublished report provided by DDSN upon request generated November 2010, SCDDSN Consumers by Age as of 9/30/10.
[141] S.C. Department of Disabilities and Special Needs, unpublished report provided by DDSN upon request generated November 2010, SCDDSN Consumers by Age as of 9/30/10.
[142] Jane Roberts, PhD & Robert Hock, PhD, University of South Carolina, Department of Psychology, unpublished report generated December 2010 Autism Brief.
[143] S.C. Board of Education, What is a penny Buying for South Carolina, Twenty-fourth Annual Reporting on the South Carolina Education Improvement Act of 1984, South Carolina Graduation Rates and Dropout Rates: A Primer. http://ed.sc.gov/agency/Accountability/Data-Management-and-Analysis/old/research/documents/Penny2008Final.pdf (last visited, January 31, 2011).
[144] South Carolina Policy Council, High School Certificates: South Carolina's Not-Quite Diplomas, http://www.scpolicycouncil.com/images/pdf/87.pdf (last retrieved February 1, 2011).
[145] S.C. Department of Education, Quick Facts: Education in South Carolina, http://ed.sc.gov/agency/Accountability/Data-Management-and-Analysis/old/research/documents/QuickFacts-100801-1.pdf (last retrieved February, 1, 2011).
[146] S.C. State Department of Education, Quick Facts: Education in South Carolina, https://apps.ed.sc.gov/agency/Accountability/Data-Management-and-Analysis/old/research/documents/QuickFacts-100801-1.pdf (last visited January 18, 2011).
[147] S.C. Department of Education, Quick Facts: Education in South Carolina, http://ed.sc.gov/agency/Accountability/Data-Management-and-Analysis/old/research/documents/QuickFacts-100801-1.pdf (last retrieved February, 1, 2011).
[148] South Carolina Policy Council, High School Certificates: South Carolina's Not-Quite Diplomas, http://www.scpolicycouncil.com/images/pdf/87.pdf (last retrieved February 1, 2011).
[149] S.C. Board of Education, What is a penny Buying for South Carolina, Twenty-fourth Annual Reporting on the South Carolina Education Improvement Act of 1984, South Carolina Graduation Rates and Dropout Rates: A Primer. http://ed.sc.gov/agency/Accountability/Data-Management-and-Analysis/old/research/documents/Penny2008Final.pdf (last visited, January 31, 2011).

rate in South Carolina is 27%.[150] High school dropouts will earn $800,000 less than college graduates throughout their lifetime. Nationally, school drop-outs make up nearly 50% of the heads-of-households who live on welfare. Further, school drop-outs account for 65% of adults who have been convicted of crimes.[151]

[150] South Carolina State Board of Education, What is a Penny Buying for South Carolina: Twenty-Fourth Annual Reporting on the South Carolina Education Improvement Act of 1984, South Carolina Graduation Rates and Dropout Rates: A Primer. December 2008.
[151] Do Something.org, 11 Facts about Dropping Out, http://www.dosomething.org/tipsandtools/11-facts-about-dropping-out (last visited January 18, 2011).

IV. Recommendations of the Joint Citizens and Legislative Committee on Children:

The well-being of the children of South Carolina is paramount. Various identified issues, concerns, and recommendations of the Committee can be found in the preceding discussions of this Annual Report. Clearly, to make informed and thoughtful decisions of policy, funding, and legislation regarding children, the Governor and the General Assembly will require access to meaningful information.

South Carolina must seek both to prevent the problems faced by its children and to mitigate the impact of the more serious problems on its children. Particularly in this time of economic recession, we must be vigilant to identify and consider both the intended and unintended consequences of each decision. We must strengthen our families, and we must promote healthy, productive behaviors by children.

The potential for improved standards of prevention and child service are dependent on leadership and the creation of innovative partnerships of the State's agencies, communities, child welfare stakeholders, and child advocates. Training, education programs, and venues for interagency collaboration will help us shape responsible cultural norms and address issues that threaten children's well-being. In these austere financial times, supporting cost-effective, proactive programs that promote children's well-being and build on existing social capital will be a powerful strategy in our struggle to protect children.

Decision makers must be well informed regarding the funding of children's services. Decisions must consider carefully and balance both the needed reductions and the resulting impact of the reductions on children's services. We must develop strategies that draw upon and enlist all the available social capital of families and communities. Strategies should address and determine which of those factors (family and community assets) our State has the ability to mobilize for the best interests of children. Informed decision making will require an accessible series of indicators of children's well-being to determine the impact of funding and budget cuts, Medicaid policy, and other policy changes over time. These indicators will help to assure that the well-being of children is considered in all current and future decisions that have substantial impact on children. The Committee urges policy makers, service providers, community leaders, and citizens to renew our efforts to support the development and well-being of children.

V. 2011 Legislative Session – Bills Endorsed by the Joint Citizens and Legislative Committee on Children:

1. **S. 292, H. 3202. Prohibit Smoking in a Vehicle with a Child Present** - Prohibits an adult from smoking in an enclosed vehicle where a child is also present provided the child is so young as to be required to ride in a child's safety car seat.

2. **S. 293**, **H.3206. Family Counseling Prior to Filing a Petition for Incorrigibility** - Requires that prior to filing a family court petition for "incorrigibility," parents must provide documentation that the family has participated in counseling.

3. **S. 294**, **H**. **3205. Codify Joint Coordinating Council on Children and Adolescents** - Codifies the existing Joint Council on Children and Adolescents which facilitates collaboration and exchange of best practices among child-serving state agencies.

4. **S. 295, H. 3204. Summer Camp Regulation Study Committee** - Creates a study committee to recommend regulations to protect the safety and health of children while in attendance at summer camps.

5. **S. 296**, **H. 3130. Sexting** - Creates a civil (noncriminal) offense of "sexting" when a minor transmits sexually explicit photographs of themselves or others to other minors.

6. **S. 297**, **H. 3203. Disturbing Schools** - Amends the offense of "disturbing schools" and increases the penalties for an offense committed by non-students.

7. **S. 298**, **H. 3201. Family Childcare Homes (Kendra's Law)** - In family childcare homes: provides for training for operators within thirty days of initial registration, notification of parental training courses, and permits corporal punishment of children only with written parental permission.

8. **S. 299**, **H.3155. Admissibility of Children's Statements to Forensic Interviewers** - Allows the admission in child abuse and neglect cases in the family courts of statements made by children less than twelve years of age to forensic interviewers.

9. **S. 300**, **H. 3200. Community Evaluations for Juveniles** - Codifies a current proviso that permits DJJ to conduct a pre-sentencing community-based evaluation of a juvenile who is not deemed to be a public safety risk

10. **S. 301**, **H.3198. Determinate Six Month Sentence for Juveniles** - Provides family court judges an additional sentencing option of imposing a six month sentence to DJJ of juveniles who commit certain crimes.

11. **S. 302**, **H. 3197. Ten Day Credit for DJJ Probationers or Parolees** - Allows a juvenile on probation or parole to receive a credit of ten days for every month of good behavior. (This credit was provided to adults in the Omnibus Crime Reduction and Sentencing Reform Act of 2010.)

12. **S. 303**, **H. 3196. Eliminate Shackling of Juveniles in Courtroom Unless Necessary** - Permits a juvenile to be shackled during a family court hearing only upon a finding by the judge that the juvenile presents a risk of safety or flight.

13. **S. 323**, **H.3195. Release of Children in DJJ Custody to Prevent Overcrowding** - Codifies a current proviso that permits DJJ to release status and misdemeanor offenders in the event of institutional overcrowding.

14. **S. 498, H. 3529. School Nutrition Bill -** Establishes nutritional standards for snacks, a la carte items in public schools with an exception for fundraising purposes.

15. **S. 445, H. 3496. Blood Borne Disease Confidentiality** - Deletes the requirement that the superintendant and school nurse be notified when a minor with AIDS or who is infected with HIV attends public school and requires schools to adopt universal precautions.

16. **S. 448, H. 3562. ATV Safety (Chandler's Law) -** Adopts safety standards and minimum age requirements for all-terrain vehicle use, exempts ATVs from taxes, and provides for titling. The bill also specifically prevents entry into private lands except when based on plain view observation or incident to an accident investigation.

Acknowledgements:

This 2010 Annual Report of the Joint Citizens and Legislative Committee on Children is the product of the hard work, co-operation, sharing of information, and collaborative spirit of the many individuals who contributed time and effort to ensure that the status of children in South Carolina was fully and accurately presented.

The Joint Citizens and Legislative Committee on Children extends its grateful appreciation to the staff of the Children's Law Center, USC School of Law, for their dedication and expertise in assisting the Committee with its research and draft preparation of this important document. In particular, we thank Jenny G. May, Research Assistant; Gwynne B. Goodlett, Senior Policy Analyst; Carolyn S. Morris, Assistant Director; and Harry W. Davis, Jr., Director.

We thank Dr. Baron Holmes for his vision, guidance, contributions, and editorial assistance.

The children of South Carolina and the members of this Committee are indebted to the following individuals for their many contributions and hard work to make this Annual Report possible:

Office of Research and Statistics, S.C. Budget and Control Board: Baron Holmes, Sarah Crawford, Teo Gamisher, Mary Payson, Charles Bradberry and Holly Battenhouse
The Children's Trust of South Carolina: Sue Williams and David Laird
The Department of Social Services: Steve Rivers and Martha Fulton
The Department of Juvenile Justice: Trudie Trotti
The Department of Mental Health: Angela Forand, Sandy Hyre, Renaye Long, Louise Johnson, and Geoff Mason
The Department of Disabilities and Special Needs: Lois Park Mole and Jennifer Buster
South Carolina Department of Education: Leon Nelson
The Department of Health and Environmental Control: Wanda Crotwell, Guang Zhao, David Thomas, Jim Ferguson, Shae Sutton, Doug Calvert, Brenda Martin, Roger Heck and Daniella Nitcheva
South Carolina Department of Alcohol and Other Drug Abuse Services: Dan Walker

We also express our appreciation to the many agency staff who work with the above individuals and whose work contributed indirectly to this 2011 Annual Report.